| NAME OF PROVIDER OR SUPPLIER ST. JOSEPH HOSPITAL STREET ADDRESS, CITY, STATE, ZIP CODE 1100 WEST STEWART DRIVE, ORANGE, CA 92868 ORANGE COUNTY (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS- | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL AND PLAN OF CORRECTION IDENTIFICATION N | | I ' ' | | PLE CONSTRUCTION | I 1 1 | (X3) DATE SURVEY COMPLETED | | |
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| ST. JOSEPH HOSPITAL (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REGULATORY OR LSC IDENTIFYING INFORMATION) The following reflects the findings of the Department of Public Health during the investigation of COMPLAINT NO: CA00141168 Inspection was limited to the specific complaint(s) investigated and does not represent the findings of | 050069 | | | | | | 03/03/2008 | | |
| PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) The following reflects the findings of the Department of Public Health during the investigation of COMPLAINT NO: CA00141168 Inspection was limited to the specific complaint(s) investigated and does not represent the findings of | | | | | | | | | |
| of Public Health during the investigation of COMPLAINT NO: CA00141168 Inspection was limited to the specific complaint(s) investigated and does not represent the findings of | PREFIX | (EACH DEFICIENCY MUST BE PRECEEDED BY FULL | | | PREFIX | (EACH CORRECTIVE ACTION | SHOULD BE CROSS- | (X5) COMPLETE DATE | |
| Representing the Department of Public Health: HFEN. HSC 1280.1 (a) HSC Section 1280 1280.1 (a) If a licensee of a health facility licensed under subdivision (a), (b), or (f) of Section 1250 receives a notice of deficiency constituting an immediate jeopardy to the health or safety of a patient and is required to submit a plan of correction, the department may assess the licensee an administrative penalty in an amount not to exceed twenty-five thousand dollars (\$25,000) per violation. c) For purposes of this section "immediate jeopardy" means a situation in which the licensee's noncompliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to the patient. DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY T22 DIV5 ART3-70223(b)(2) Surgical Service General Requirements (b) A committee of the medical staff shall be | Event ID:E | of Public Health COMPLAINT NO: CA Inspection was limite investigated and doe a full inspection of the Representing the Representing the Inspection of the Inspecti | during the invertional | complaint (s) e findings of blic Health: illity licensed ection 1250 estituting an safety of a a plan of assess the amount not is (\$25,000) "immediate he licensee's uirements of use, serious IMMEDIATE Il Service | 6:15: | 19PM | | | |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

State-2567 1 of 5

TITLE

(X6) DATE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | A. BUILDIN | PLE CONSTRUCTION | (X3) DATE SU COMPLET | |
|---|--|---|--|---------------------|-----------------------------------|---|--------------------------|
| | | 050069 | | B. WING | | 03/0 | 3/2008 |
| | OVIDER OR SUPPLIER PH HOSPITAL | | STREET ADDRESS, | | ZIP CODE E, ORANGE, CA 92868 C | RANGE COUNTY | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX TAG | (EACH CORRECTIVE AC | AN OF CORRECTION CTION SHOULD BE CROSS- APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| | Continued From page 1 | | | | | | |
| | assigned responsibility | for: | | | | | |
| | (2) Development, mof written policies a with other appropriadministration. Polici governing body. Professional the administration and appropriate. This REGULATION: is Based on interview and anesthesiologist with Patient #1 in the was written on the stime out, and the were not reviewed defailed to follow their to prevent wrong sit the wrong knee for Patient with other to prevent wrong sit the wrong knee for Patient administration. | and procedures in ate health profess ces shall be approcedures shall be a and medical staff what and record review did not verify the ne OR, the surgical count board patient's history a suring the time out. Universal policy and te surgery being profess count patient and record review and record | consultation sionals and oved by the approved by the approved by the approved by the approved is districted by: The nurse surgery site all procedure prior to the and physical the hospital districted by the approved by the | | | | |
| | Findings: | | | | | | |
| | On 3/3/08, review procedure titled "U Wrong Person, Procedures" she anesthesiologist wou procedure and site a patient's involvement The policy and procedures the conservance of the policy schedule for Additionally, the policy | Iniversal Protocol cedure, Site Operatowed the null verify the corror this would occur in the OR suite cedure also showed in, history and placcuracy during the | to Prevent tions And/or arse and rect person, cur with the if possible. In the if the nurse mysical, and the time out. | | | | |
| Event ID:E | BOCI11 | | 5/12/2008 | 6:15: | 19PM | | |
| LABORATOR | Y DIRECTOR'S OR PROVID | ER/SUPPLIER REPRESE | NTATIVE'S SIGNA | TURE | TITL | E | (X6) DATE |

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| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULT | IPLE CONSTRUCTION | (X3) DATE SUI COMPLET | |
|--------------------------|--|---|---|---------------------|--|-----------------------------|-----------|
| | | | B. WING | | 03/03/2008 | | |
| | OVIDER OR SUPPLIER PH HOSPITAL | | STREET ADDRESS 1100 WEST STE | | ZIP CODE E, ORANGE, CA 92868 ORAN | GE COUNTY | |
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| | Continued From page 2 | | | | | | |
| | operative site/side w count board after the correct site/side verifie | time out has take | - | | | | |
| | During interview, pre-operative RN schedule for Patier patient was to have 2/15/08. However, interviewed the patie for the left knee. Ac she then notified the person, about the schedule to designate site. She also stat (operating room) anesthesiologist about RN A stated she also and spoke with the the surgical consent for Review of the facility surgery schedule listing "arthroscopy/chronding omy knee, right." The out and the word left word le | at #1's surgery se a right knee arth when the preoper, he stated the cording to pre-oper estated to change est the left knee as the death of the correction. It is not to the left knee as the correction. It is not to the left knee as the correction. It is not to the left knee as the correction. It is not the left knee as the correction. It is not the left knee as the correction and the left knee knee word right had be the left knee knee word right had be the knee knee knee knee knee knee knee kn | the surgery showed the proscopy on the proscopy on the surgery was eative RN A, the surgery was eative RN A, the surgery he operative to the OR with the pre-operative erating suite change on the three was showed an debridement ee." | 0.45 | 10PM | | |
| Event ID:I | BOCI11 | | 5/12/2008 | 6:15: | 19PM | | |
| LABORATOR | Y DIRECTOR'S OR PROVID | ER/SUPPLIER REPRESE | NTATIVE'S SIGNA | TURE | TITLE | <u> </u> | (X6) DATE |

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|---|--|--|---|---------------------|--|-----------------------------|-----------|
| 050069 | | | B. WING | | 03/03/2008 | | |
| NAME OF PROVIDER OR SUPPLIER ST. JOSEPH HOSPITAL | | | STREET ADDRESS 1100 WEST STE | | ZIP CODE E, ORANGE, CA 92868 ORAN | GE COUNTY | |
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| | Continued From page 3 | | | | | | |
| | was awake upon arritechnician stated the patient's right leg. To procedure was writted located in the OR suited. At 1200 hours on 3/2 interviewed. The nurse Patient #1 in the precedent was marked patient to the surger she went to set up to set up for a right knew wrote right knee on word "procedure." As for the surgery she on the right knee and been done on the right knee and been done on the right knee and the surgery she was a surgery she was not the right knee and been done on the right knee and the surgery she was not the right knee and the surgery she was not the surgery she was not the right knee and the surgery she was not the right knee and the surgery she was not the right knee and the surgery she was not the right knee and the surgery she was not the sur | rival in the OR suinere was no mathe OR technician en as right leg or e. (3/08, Circulating Notes stated she had operative area and experience of the patient for the experience of the patient for the experience of the count board experience of the patient for the experience of the count board experience of the count was discovered at time out was discovered experience of the count was discovered experience of the co | urse C was spoken with saw that the to bring the stated when surgery; she o stated she next to the g the patient of a "mark" cal prep had e stated she wo patient and stating the patient, of done with one prior to consent out history and me out prior | | | | |
| | The violation(s) has ca | used or is likely to ca | iuse, | | | | |
| Event ID: | | _ | 5/12/2008 | | 19PM | | |
| LABORATOR | Y DIRECTOR'S OR PROVIDE | ER/SUPPLIER REPRESE | NTATIVE'S SIGNA | TURE | TITLE | | (X6) DATE |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|-----------------|--|---|------|----------------------------|--|
| | | 050069 | | B. WING | | 03/0 | 3/2008 | |
| | | | | ESS, CITY, STATE, ZIP CODE STEWART DRIVE, ORANGE, CA 92868 ORANGE COUNTY | | | | |
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| | Continued From page 4 | | | | | | | |
| | serious injury or death | to the patient(s). | | | | | | |
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